BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **MELVYN V. MAHON, M.D.** Holder of License No. **42434** For the Practice of Allopathic Medicine In the State of Arizona.	**Case No: MD-11-0573A** **INTERIM FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR SUMMARY RESTRICTION OF LICENSE**

INTRODUCTION

The above-captioned matter came on for discussion before the Arizona Medical Board ("Board") at an emergency Board teleconference meeting on May 12, 2011. After reviewing relevant information and deliberating, the Board voted to consider proceedings for a summary action against Melvyn V. Mahon, M.D.'s ("Respondent") license. Having considered the information in the matter and being fully advised, the Board enters the following Interim Findings of Fact, Conclusions of Law and Order for Summary Restriction of License, pending formal hearings or other Board action. A.R.S. § 32-1451(D).

INTERIM FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 42434 for the practice of allopathic medicine in the State of Arizona.

3. On April 22, 2011, the Board received a report from a regional medical center that some of Respondent's cardiology privileges had been summarily suspended on April 21, 2011, based upon concerns about his technique and judgment in five separate cases.

4. The Board's medical consultant conducted an independent review of four of the five cases cited by the regional medical center and found deviations from the standard of care in all of them.

5. Patient JN had multiple medical issues and had recurrence of Acute Cardiac syndrome ("ACS"). He refused intervention on first day of admission on October 14, 2010. He then was found to have DVT and anticoagulants were continued. Intervention from pain management made his cardiac symptomatology better. On October 17, 2010, JN agreed to cardiac catheterization but by this time he was in need of continued anticoagulation and his cardiac symptoms were better. Instead of risk stratification with a stress test, Respondent elected to go on with cardiac catheterization and an angioplasty, and instead of using a vascular closure device, elected to leave arterial sheath in for 6 hours and used manual compression. Unfortunately for the patient, a delayed access site bleed occurred with continued anticoagulation resulting in the need to transfer JN to tertiary care center.

6. Patient WK had severe COPD and following steroids, developed symptomatology of closing feeling of throat, chest pain, diarrhea and nausea. She had normal EKGs, Echocardiogram and multiple sets of normal biomarkers. Without first seeing the patient, Respondent ordered and performed a pharmacological stress test and read it as negative for ischemia. He then performed cardiac catheterization in an anticoagulated patient without waiting for the INR to come down to less than 1.4. At cardiac catheterization, he entered the external iliac artery instead of femoral. Once he entered the artery, within 15 minutes (at 4:48PM) it was evident that patient was bleeding with groin hematoma. Instead of trying to find the etiology of bleed and control it, he went on with the procedure. With the patient's status deteriorating, Respondent found out that bleed was from iliac artery (at 5:09 PM). He did not stop Integrilin or take steps to control the bleeding until 5:24 PM when he elected to stop Integrilin infusion. Respondent banked

on blood products, then waited to call for surgical help at least 36 minutes from first notice of bleed and 15 minutes from when he knew the site of bleed. All of this led ultimately to coagulopathy and multi organ failure. When the case could not be handled further at HRMC; patient was transferred to a "Tertiary care" facility in Las Vegas.

7. Patient PC had h/o esophageal ulcer/bleed, acute renal failure that recovered, past pancreatitis and some risk factors for CAD. Chest pain was the presenting symptom and PC had acute pancreatitis. In spite of clear diagnosis and renal insufficiency Respondent went on with a CT scan of the chest to rule out aortic dissection and cardiac catheterization. He used therapeutic anticoagulation in spite of the consulting GI doctor who recommended against using another anticoagulant Integrilin. Anticoagulation was further continued for another 60 or so hours until changed to prophylactic dose by a different physician. Cardiac catheterization revealed normal coronaries, normal/high ejection fraction and hypertension. Respondent did not bring the blood pressure down during and at the termination of cardiac catheterization. The patient developed renal failure.

8. RK was documented to have COPD and chronic CHF and was admitted on February 17, 2011 with increasing shortness of breath. No chest pain was documented and the patient had a history of negative angiogram in November, 2010. She was in cardiac failure with exacerbation of COPD. RK also had renal insufficiency with GFR varying between 30 and 28. On the basis of elevation of Troponin Respondent made the diagnosis of NSTEMI without other corroborative symptoms, new changes in EKG (showing paced rhythm) or a demonstration of rise and fall in troponin levels. He even started the patient on a full dose of Integrilin, which was not indicated and was double the recommended dose. In view of patient's renal insufficiency, this course of treatment exposed the patient to the potential of excessive bleeding. In spite of indications that

patient did not have a NSTEMI, Respondent recommended a cardiac catheterization urgently /emergently and went on with the procedure the following day (February 18, 2011) without making any provision to protect the kidney from the potential worsening of renal insufficiency. He ultimately did stop Integrilin in the catheterization lab. Cardiac catheterization showed normal coronary arteries, thus negating the diagnosis of NSTEMI. It also showed left ventricular dysfunction, reduced cardiac output, pulmonary hypertension and elevated pulmonary artery wedge pressure. Determination of wedge pressure needs inflation of balloon in pulmonary capillaries. The procedure terminated at 3:24 PM. Natrecor and nitroglycerin transfusions were ordered. Orders, including Mucomyst, were made in an attempt to thwart worsening of renal function related to the use of contrast material. At 5:15 PM patient developed massive hemoptysis, she was intubated into right bronchus, continued to deteriorate and was declared dead at 5:51 PM.

9. The standard of care when considering catheterization in a patient who is anticoagulated requires a physician to stratify the risk by offering noninvasive testing such as a stress test.

10. Respondent deviated from standard of care when he did not risk stratify JN before cardiac catheterization on October 17, 2010.

11. The standard of care requires a physician to consider use of a vascular closure device if cardiac catheterization becomes necessary in a patient who is anticoagulated and is in need of continued anticoagulation.

12. Respondent deviated from standard of care when he elected not to close the arterial access site with a closure device with continued anticoagulation.

13. The standard of care requires a physician to bring down the INR to appropriate levels (1.4) before subjecting a patient to an invasive procedure.

14. Respondent deviated from the standard of care when he elected to take patient to the catheterization lab with an excessively elevated INR.

15. The standard of care requires a physician to discontinue anticoagulants in the presence of bleeding and make attempts to stop the bleeding before continuing the procedure.

16. Respondent deviated from standard of care when he did not immediately stop Integrilin and order FFP or other blood products once it was evident that patient was bleeding.

17. The standard of care requires a physician to address the etiology of bleeding and to correct it immediately, if possible.

18. Respondent deviated from standard of care when he did not even attempt to find out the source of bleeding when it was first evident in patient WK.

19. The standard of care requires a physician to use Integrilin only when ACS is a strong consideration.

20. Respondent further deviated from standard of care when he started Integrilin without proper indication for its use.

21. The standard of care requires a physician to reduce the dose of Integrilin to half when GFR is less than 50.

22. Respondent deviated from standard of care when he prescribed full dose Integrilin in a patient with GFR of 28 thus raising the prospects of a bleed.

23. The standard of care requires a physician to consider non-cardiac etiologies of chest pain in spite of negative clinical and non-invasive work up for cardiac disease.

24. Respondent deviated from the standard of care when he failed to consider a diagnosis of pancreatitis as the etiology of chest pain in PC in absence of any objective evidence of cardiac origin.

25. The standard of care also requires a physician to consider emergent cardiac catheterization if objective signs are present which suggest NSTEMI (Non ST elevation MI) with continued chest pain.

26. Respondent deviated from standard of care in delaying the cardiac catheterization for several hours if he seriously considered a diagnosis of NSTEMI/unstable angina with continued chest pain.

27. The standard of care requires a physician to reduce the amount of contrast material used to minimum necessary in patients with renal insufficiency and use alternative modes to look at left ventricular function and structure.

28. Respondent deviated from standard of care when he failed to take measures to protect the kidneys with renal insufficiency when he ordered two studies with contrast.

29. PC developed acute renal failure as a result of unnecessary use of contrast. For WK the performance of an unnecessary procedure led to multi organ failure. In the case of RY there was the potential for renal function worsening when Respondent undertook cardiac catheterization in absence of proper indications. JN developed access site bleed and needed to be transferred to tertiary facility.

INTERIM CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent, holder of License No. 42434 for the practice of allopathic medicine in the State of Arizona.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public."),

3. Based on the foregoing Interim Findings of Fact and Conclusions of Law, the public health, safety or welfare imperatively requires emergency action. A.R.S. § 32-

1451(D).

ORDER

Based on the foregoing Interim Findings of Fact and Conclusions of Law, set forth above,

IT IS HEREBY ORDERED THAT:

1. Respondent's license to practice allopathic medicine in the State of Arizona, License No.42434, is summarily restricted in that Respondent shall not practice invasive or interventional cardiology until Respondent applies to the Board and receives permission to do so. For purposes of this Practice Restriction, the phrase "invasive or interventional cardiology" shall be interpreted to prohibit Respondent from performing the following procedures: left heart catheterization; right heart catheterization; ventriculogram; insertion of percutaneous intra-aortic balloon pump catheter; endomyocardial biopsy; coronary angioplasty; directional coronary artherectomy; rotational artherectomy (Rotoblater); and coronary stent placement; diagnostic cardiac; diagnostic peripheral - extremities; diagnostic carotid and cerebral; inferior vena cava filter placement; therapeutic angiography (i.e, thrombolysis); interventional peripheral (angioplasty, stents, thrombolysis); diagnostic venography; and intra-aortic balloon pump (IABP).

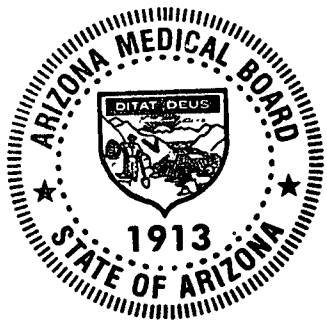
2. This is an interim order and not a final decision by the Board regarding the pending investigative file and as such is subject to further consideration by the Board.

3. The Interim Findings of Fact and Conclusions of Law constitute written notice to Respondent of the charges of unprofessional conduct made by the Board against him. Respondent is entitled to a formal hearing to defend these charges as expeditiously as possible after the issuance of this order.

4. The Board's Executive Director is instructed to refer this matter to the Office of Administrative Hearings for scheduling of an administrative hearing to be commenced as expeditiously as possible from the date of the issuance of this order, unless stipulated and agreed otherwise by Respondent.

DATED this 12th day of May, 2011.

ARIZONA MEDICAL BOARD

(SEAL) 

By: _____
LISA S. WYNN
Executive Director

ORIGINAL of the foregoing filed this 12th day of May, 2011, with:

The Arizona Medical Board
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Scottsdale, AZ 85258

Executed copy of the foregoing mailed by U.S. Mail this 12th day of May, 2011, to:

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Executed copy of the foregoing mailed by U.S. mail this 12th day of May, 2011, to:

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